Katie Hobbs
Governor

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Michael Wisehart
Director

MEDALLION PROGRAM

FREE IDENTIFICATION TAG - CHOOSE ONE BELOW

To be used for quick identification purposes by any emergency response team –police, paramedics, firefighters, etc.

The Arizona Department of Economic Security/Division of Developmental Disabilities (DDD) is offering a medallion wrist band or shoe tag for adults and children. This identification will help first responders in case of an emergency or if a DDD member becomes lost in the community. Each identification tag includes the DDD "case number" and a 24-hour phone number for first response emergency personnel to contact. Expect 4-6 weeks for delivery.

A HIPAA Form is needed for DDD to provide emergency information to Police and Emergency Personnel, if they contact DDD. Please complete and return the attached form to your support coordinator to receive an ID tag.

Please complete and return this form to your Support Coordinator.

For any questions email DDDMedallionProgram@azdes.gov

Support Coordinator *(please print)*: _____ Mail Drop: _____

HIPPAA Form Completed: ☐ Yes ☐ No

Member Name: _____ ASSISTS #: _____

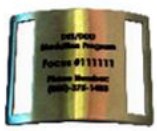
Address: _____

City, State, Zip Code: _____

Phone Number: _____ Responsible Person/Guardian Name: _____

If you have any questions, please contact your Support Coordinator.

PLEASE CHECK ONE



☐ Shoe Tag

☐ Black Wrist Band

☐ Wrist Band

See page 2 for EOE/ADA disclosures

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Insurance Portability and Accountability Act of 1996
45 C.F.R. § 164.508

Name of person/organization disclosing health information:

Department of Economic Security / Division of Developmental Disabilities (DDD)

Name of individual whose protected health information may be disclosed:

_____

The protected health information which may be disclosed includes address and applicable individual, parent or guardian contact information as well as any health care information relating to the individual that the DDD determines is needed by the caller in order to provide appropriate medical treatment to the individual or to provide for the individual's safety and welfare until the person's parent guardian, or responsible party is able to resume custody of the individual. This information will be disclosed by DDD to a caller who obtains the DDD telephone number from an identification tag provided to the individual by DDD. Upon receipt of a call for this information, DDD will verify that the caller obtained the phone number from the identification tag. The information will be disclosed to the caller (generally expected to be law enforcement, emergency medical providers, or individuals attempting to assist the individual) in the event the individual named above becomes ill, lost, injured or otherwise physically or mentally impaired and needs assistance.

The release of protected health information will be to assist rescuers in aiding the individual named above.

This authorization will expire on the date that the individual is no longer eligible for DES/DDD. I understand that once this expiration condition occurs, the Department will not be able to provide information pursuant to this release even though the individual may still be wearing the identification tag.

I understand that I may revoke this authorization at any time by written notice to DDD, except to the extent that the disclosure authorized has been acted upon prior to the receipt of any written revocation.

I understand that I do not have to sign this authorization. I understand that a health care provider or health plan may not condition treatment, payment, enrollment or eligibility in a health plan or eligibility for health care benefits on my signing this authorization except as provided under state or federal law.

I understand that once the records and information authorized herein are disclosed, they could be re-disclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. However, health care service providers generally are bound by law to maintain the confidentiality of health information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, substance abuse, psychological or psychiatric conditions or genetic testing.

I understand that I may have a copy of this signed authorization if requested.

Full name of individual/member or personal representative *(please print)*: _____

Signature of individual/member or personal representative (If applicable): _____

Date signed: _____

Description of personal representative's authority: _____

Signature of staff: _____

A FACSIMILE OR PHOTOCOPY OF THIS AUTHORIZATION IS CONSIDERED TO BE AS AUTHENTIC AS THE ORIGINAL.